#MoSummit2016

DIFP
Department of Insurance, Financial Institutions & Professional Registration

2016 Legislative Briefing

2016 Director's Regulatory Summit

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DIFP
Department of Insurance, Financial Institutions & Professional Registration

Speakers

Rich Lamb, Legislative Director, Missouri DIFP
Angela Nelson, Market Regulation Division Director and Chief Industry Liaison, Missouri DIFP

HB 2194

Sponsored by: Rep. Denny Hoskins

Sen. Jay Wasson

Covers five different topics, including:

- Worker's Compensation
- Company Directors Affidavits for Market Regulation Reports
- Transfer of Auto/Homeowners Policies Among Affiliates
- P/C Insurers Issuing Life Coverage Outside of the United States
- Self- Storage Insurance

HB 2194

Modifies section **287.955** relating to **Worker's Compensation Insurance**.

- Removes a standalone requirement that the schedule rating plan must be actuarially justified. However, Missouri law still requires that all rating plans are actuarially justified and do not result in rates that are "excessive, inadequate or unfairly discriminatory" (287.950).

- Also adds that any changes to individual risk premiums modifications must be based on changes in the employers operations or risk characteristics.

HB 2194

Modifies section **374.205** relating to **insurance company director affidavits.**

- When the Dept. of Insurance issues a market conduct report, the new law allows insurance companies to file one affidavit indicating acceptance of such reports rather than requiring all directors of a company to file an affidavit. This single affidavit will be executed by the insurance company's general counsel or chief legal officer.

- Insurance company directors will still be required to file affidavits within 30 days of the issuance of an adopted company regulation report stating under oath that they have received a copy of that report.

HB 2194

Changes sections **375.004** and **378.118** relating to the **transfer of auto/homeowners policies among affiliates under the same holding company.**

- When an insurer transfers an auto or homeowners policy among affiliated insurers within an insurance company holding system the insurer accepting the transfer must provide a notice to the insured that their coverage is with a new company.

- The transfer is effective upon the expiration of the existing policy, in other words, upon renewal.

- If the transfer does not result in coverage substantially equivalent to the coverage that was contained in the policy being assigned or transferred, the insurer shall, at least fifteen days in advance of the effective date of the assignment or transfer, notify the policyholder that some coverage provisions will change due to the assignment or transfer, advise the policyholder to refer to the new policy for coverage details, and provide a copy of or access to the replacement policy form or the executed replacement policy.

HB 2194

Changes section **379.125** relating to **polices issued outside the U.S.**

- Authorizes P/C insurers and reinsurers to write limited amounts of life insurance business outside of the United States which is written or assumed as a rider attached to a base policy, provided the aggregate premium assumed annually does not exceed 3% of the capital and surplus of the company as of December 31 of the previous year.

HB 2194

Creates a new section of **379.1640** that establishes a regulatory structure for **self-storage insurance.**

- Limited lines self-service storage insurance producers, operators, employees and authorized representatives may offer and disseminate self-service storage insurance policies in an amount not to exceed $5,000 per customer per unit.

HB 1682

Rep. Keith Frederick

Sen. Jay Wasson

Makes changes relating to health care professionals and also addresses:

- Contractual requirements between optometrists and health carriers.
- Prescription eye-drop refills.

HB 1682

Creates a new section of **376.685** relating to **contracts between optometrists and health carriers.**

- Prohibits an agreement between a health insurer that writes vision insurance and an optometrist from requiring that the optometrist provide additional services or materials at a fee limited or set by the insurer, unless the services or materials are reimbursed as covered services under the contract.

- A provider is prohibited from charging more for services or materials that are not covered under a health benefit or vision plan than the usual and customary rate they charge for those services or materials.

- Prohibits a vision care insurance policy or vision care discount plan that provides covered services for materials from having the effect, directly or indirectly, of limiting the choice of sources and suppliers of materials (i.e. lenses) by a patient of a vision care provider.

- Optometrists are not prohibited from opting in to an optometric services discount plan.

HB 1682

Changes section **376.1237** by extending the sunset provision for coverage of **early refills of prescription eye drops** from January 1, 2017 to January 1, 2020.

- This provision can also be found HB 1816, SB 608, SB 635, SB 865, and SB 973.

HB 1976

Rep. Denny Hoskins

Sen. Jay Wasson

- Addresses several subjects including regulations on towing companies and the use of auto cycles.

- Modifies provisions concerning extended service contracts.

HB 1976

Makes changes to sections **385.200, 385.206, 385.300, 385.306** relating to **service contracts.**

- Expands the definition of "motor vehicle extended service contract" to include a contract or agreement for repairs of certain road hazard damages, replacement of a vehicle key or key fob when inoperable, stolen or lost, or other services approved by the Director.

- Specifies that a refund of the service contract after the required free look period may be effectuated through a service contract provider or a person permitted to sell motor vehicle extended service contracts.

SB 608

Sen. David Sater

Rep. Sue Allen

- SB 608 covers several different topics including;

- Certificates of need, MO Health Co-payments and missed appointments, cost transparency requirements for health care providers, as well as some changes related health care professionals.

- Medication Synchronization
- Pharmacy Benefit Managers and the Maximum Allowable Cost List
- Occupational Therapy Co-Payment Parity
- Contractual Payment Transparency

SB 608

- Creates a new section of **376.379** related to **prescription drug synchronization.**

- Requires health carriers or managed care plans offering health benefit plans with prescription drug coverage to offer medication synchronization services that align prescription refill dates.

- Charging more than the normal co-payment is prohibited for quantities less than prescribed.

- Also found in SB 865.

SB 608

Adds a new section of **376.388** relating to **Pharmacy Benefit Managers.**

- A contract between a pharmacy benefit manager (PBM) and a pharmacy shall include “the sources utilized to determine maximum allowable cost and update such pricing information at least every seven days.”
- A PBM shall establish a procedure to eliminate products from the maximum allowable cost list of drugs (the MAC list) or modify maximum allowable cost pricing within seven days if the drugs do not meet the standards as provided in the law.
- A PBM shall reimburse pharmacies for drugs subject to maximum allowable cost pricing based upon pricing information which has been updated within seven days.
- A drug shall not be placed on the MAC list “unless there are at least two therapeutically equivalent multi-source generic drugs, or at least one generic drug available from at least one manufacturer and is generally available for purchase from national or regional wholesalers.”
- All contracts shall include a process to internally appeal, investigate, and resolve disputes regarding MAC pricing.
- Also found in SB 635 and SB 865.

SB 608

- Adds a new section of **376.1235** relating to **Occupational Therapy Co-Payment Parity.**

- Services rendered by licensed occupational therapists cannot require a higher co-payment or coinsurance than is required for the services of a primary care physician office visit. Health carriers are required to clearly state the availability of occupational therapy services.

- Also found in SB 635.

SB 608

Creates a new section of **376.2020** concerning **contractual payment transparency between health carriers and health providers.**

- No contract in existence, or entered into on or after August 28, 2016, between a health carrier and a health care provider shall be enforceable if such provision prohibits, conditions, or in any way restricts any party to such contract from disclosing to an enrollee the contractual payment amount for a health care service if such payment amount is less than the health care provider's usual charge for the health care service;

- And if such contractual provision prevents the determination of the potential out-of-pocket cost for the health care service by the enrollee.

HB 2029

Rep. Denny Hoskins

Sen. David Sater

Adds three new sections of law, **376.2030, 376.2034, 376.2036** relating to **Step Therapy.**

- Health insurance and health benefit plans delivered, issued for delivery, or renewed on or after January 1, 2018 are required to provide health care providers access to a clear, convenient, and readily accessible process to request a step therapy override exception determination for prescription drugs that are restricted for use via a step therapy protocol.

SB 833

Sen. Jamilah Nasheed

Rep. Travis Fitzwater

This bill creates several new provisions of law concerning:

- Financial transactions related to gambling boats, financial institutions and the practice of land surveying.
- Excepted Benefit Plans
- Closing Protection Letters

SB 833

Adds a new section of **376.998** regarding **excepted benefits plans.**

- This section provides that excepted benefit plans are exempt from health insurance mandates enacted on or after August 28, 2016 unless they are specifically included. It also allows the DIFP Director to issue a bulletin exempting a type of excepted benefit plan from notice or disclosure requirements for services that by custom are not covered by the particular type of excepted benefit plan being exempted.

SB 833

Modifies section **381.022** and **381.058** regarding **title insurance and closing protection letters.**

- Requires that a closing protection letter be issued by a title insurer, agent, or agency in all residential real estate transactions where title insurance is provided.

SB 947

Sen. Mike Parson

Rep. Elijah Haarh

Creates insurance requirements for **transportation network companies** by adding the new sections of **379.1700-378.1708.**

- A TNC driver or the TNC Company, on the driver's behalf, is required to maintain primary automobile insurance coverage.

- Effective April 1, 2017.

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SB 865

Sen. David Sater

Rep. Lynn Morris

This bill covers several different topics including;

- Pharmacy regulation and medication dispensing, medication synchronization, PBM MAC List, early eye-drop refills
- Health Insurance Rate Review

SB 865

Health Insurance Rate Review

- Plans in the individual and small group market will file rates for their health benefit plans with the Department of Insurance.
- The Department will also make proposed rates publicly available and provide a mechanism to allow Missourians to make public comments regarding the proposed rates.
- Within 60 days of the rates being filed, the Director must provide written notice to the health carrier as to whether the rates are reasonable or unreasonable. If the Director finds that the health carrier's rates are unreasonable, the carrier may amend its rates, request reconsideration from the Department, or implement the proposed rate.
- If the health carrier decides to implement a rate the Department has determined to be unreasonable, the Department will make the "unreasonable rate" determination public.
- The Department will publish the final rates on its website no earlier than 30 days prior to the first day of open enrollment.
- Grandfathered plans (plans issued prior to March 23, 2010) and Excepted Benefit Plans (that are not comprehensive medical plans) will submit their rates to the Department for informational purposes only.
- **Sections 374.185, 376.465, 379.934, 379.936, 379.938, 379.940**

HB 2150

Rep. John Weimann

Sen. Paul Wieland

Establishes the **"Unclaimed Life Insurance Benefit Act"** and creates the new sections of **376.2050-376.2053.**

- Requires life insurers that have used the Master Death File (MDF) to identify deceased annuitants to compare certain life policies against the MDF to find potential beneficiaries.

- The new law also require all life insurers to compare policies issued after Jan. 1, 2018 against the MDF on at least a semiannual basis to find potential matches on insureds who have passed away.

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Any questions

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